STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioners **File No. 87394-001-SF**

v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 5th day of March 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 25, 2008, XXXXX, on behalf of himself and his wife XXXXX (the Petitioners), filed a request for external review with the Commissioner of Financial and Insurance Services under Public Act No. 495 of 2006, MCL 550.1951 *et seq*. The Commissioner reviewed the material submitted and accepted the request on February 1, 2008.

As required by Section 2(2) of Act 495, the Commissioner conducts this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information it used in making its adverse determination. The Commissioner received BCBSM's response on February 11, 2008.

The issue in this external review can be decided by analyzing the contract that defines the Petitioners' health coverage, the BCBSM Comprehensive Health Care Copayment Certificate Series CMM 100-90/10 (the certificate), which is amended by the ASC Plan

Modification 2943-City of Detroit (the plan modification). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). The case does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioners have health care coverage under a self-funded plan through XXXX employment with the City of Detroit. BCBSM administers the plan.

On January 3, 2007, XXXX received chiropractic x-rays and physical therapy. The approved amount for this care was applied to her deductible. The Petitioners believe that BCBSM erred in applying the approved amount to the deductible.

On April 12, 2007, XXXXX underwent an outpatient colonoscopy. BCBSM applied a deductible and copayment before making its reimbursement for this care. The Petitioners believe that no deductible or copayment should have been applied.

The Petitioners appealed BCBSM's processing of these claims. BCBSM held a managerial-level conference on November 28, 2007, and issued a final adverse determination dated January 9, 2008, confirming its decision on the application of the deductibles and copayments.

III
ISSUE

Did BCBSM correctly apply deductibles and copayments to the care provided the Petitioners?

IV
ANALYSIS

Petitioner's Argument

Regarding XXXXX's colonoscopy, the Petitioners say their coverage was modified effective July 15, 2006, to include routine colonoscopies and other preventative services without copayments or deductibles. The Petitioners believes that the hospital where the colonoscopy

was performed was unaware that routine colonoscopies were a covered benefit and therefore filed the claim with a diagnosis of diverticula. The Petitioners say the doctor suggested a follow up screening for XXXXX because he had a polyp removed the previous year. The Petitioners believe that the colonoscopy was a preventative service and no deductibles or copays should have been applied.

Regarding XXXXX chiropractic x-rays, the Petitioner's believe this care should be paid under the chiropractic benefit where there is only a $10.00 copayment. Instead BCBSM applied the approved amount for this care ($129.06) to XXXXX $175.00 annual deductible for general benefits.

BCBSM's Argument

BCBSM says it approved $1,389.73 for XXXXX colonoscopy. That amount was reduced by the $175.00 applied to his annual deductible and his 10% copayment of $121.47. BCBSM then paid the providers $1,093.26.

BCBSM says it pays claims the way they are submitted by providers. In this case the procedure was billed with the diagnosis of "diverticula of colon." The claim did not indicate the procedure was preventative (i.e., a routine colonoscopy).

Regarding XXXXX's January 3, 2007, chiropractic care, BCBSM says the certificate's $10.00 copayment applies only to chiropractic manipulations. When a chiropractor provides other services, such as x-rays or physical therapy, the charges are first applied to the $175.00 annual deductible. Therefore, BCBSM applied its approved amount of $129.06 for the January 3, 2007, x-rays and physical therapy to the annual deductible because that care provided was not chiropractic manipulation.

BCBSM believes that it has paid for the Petitioners' care in accordance with the terms of the Petitioners' certificate.

Commissioner's Review

The language of the Petitioners' certificate and plan modification is clear. A $175.00 deductible and 10% copayment are applied to most services covered under the certificate. Exceptions to this provision include certain preventative services and chiropractic manipulation of the spine. The Petitioners argue that the care they received on April 4, 2007, and January 3, 2007, fall in these exceptions and BCBSM improperly applied deductibles and copayments for this care.

When processing claims, BCBSM must rely on what is filed by the doctor. Although the Petitioners say it was miscoded, BCBSM has established that XXXXX colonoscopy claim was filed by the doctor with a diagnosis of diverticula of colon. This does not indicate a routine or preventative service but rather a diagnostic procedure. Moreover, XXXXX indicated he does have diverticula and that his doctor suggested a follow-up screening after a polyp was removed in the previous year. It appears clear that the doctor ordered the colonoscopy because of this condition.

While the plan modification added routine colonoscopy as a benefit without a deductible or copayment, it did not change the coverage for diagnostic tests and services (including a diagnostic colonoscopy). Therefore, the Commissioner finds that BCBSM's application of the $175 deductible and 10% copayment to the amounts it approved for XXXXX diagnostic colonoscopy are consistent with the terms of the certificate.

XXXXX January 3, 2007, care was for x-rays and physical therapy. The Commissioner concludes that the $175.00 deductible does apply to these services. There is no indication that the services were for manipulation of the spine. The plan modification imposed a $10.00 per visit copayment for chiropractic manipulations but otherwise did not alter the coverage for chiropractic services (including radiological services); they are subject to the deductible and 10% copayment requirements. The Commissioner finds that BCBSM acted appropriately when it applied the $129.06 it approved for XXXXX care to her annual deductible.

V
ORDER

BCBSM's final adverse determination of January 9, 2008, is upheld. BCBSM is not required to pay an additional amount for the care provided the Petitioners on January 3, 2007, and April 12, 2007.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.